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***STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
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Mr. Chairman and Members of the Committee:

On behalf of DAV (Disabled American Veterans) and our 1.3 million members, all of whom are wartime injured or ill veterans, I am pleased to present our views at this oversight hearing focused on post traumatic stress disorder (PTSD) in the veterans' population and the effectiveness of the mental health treatment and services provided to these veterans by the Department of Veterans Affairs (VA). We appreciate the Committee's attention to this important issue. Timely access to VA's specialized mental health services is critical to many DAV members.

Assessing the Effectiveness of VA Mental Health Programs, Including Post-Traumatic Stress Disorder and Suicide Prevention Efforts

VA mental health care has come a long way in meeting veterans where they are—at demobilization sites, on college campuses, at Transition Assistance Program briefings and in military hospitals. It has also deployed new information technology to better inform the tech-savvy new generation of post-9/11 veterans and their family members. Today, it offers web-based curriculum, self-help apps, and a website with a peer-to-peer focus to provide information and awareness to all eras of veterans, service members and their family members, in addition to community health care practitioners. VA has the distinction of being the only national health care provider to integrate mental health care services into primary care. Its comprehensive and holistic approaches to managing care for vulnerable veterans have yielded good outcomes, including increasing the expected longevity of veterans with severe and chronic mental health conditions.

We acknowledge and commend the dedication of VA mental health clinicians who compassionately care for our nation's combat veterans struggling with post-deployment mental health issues, including PTSD. While VA remains the leader in providing our nation's veterans high quality mental health services and specialized treatment following wartime service, the Department must find new ways to improve access, decrease veterans' suicide and meet the unique needs of a diverse population.

Use of Clinical Practice Guidelines

VA's National Center for PTSD has been a global leader in developing techniques to screen, diagnose, treat and measure clinical outcomes for people with post-traumatic stress reactions. Based largely on its work, a VA and the Department of Defense (DOD) working group was convened to develop clinical practice guidelines based on review of evidence-based practices for preventing, identifying, managing and treating acute stress reactions and PTSD. We understand that the 2010 guidelines currently used are being updated. Existing guidelines emphasize the use of normalization, expectation of recovery and acute symptom management, as necessary, for acute disorders. For chronic and severe PTSD the working group gave its strongest recommendations for the use of psychotherapy including trauma-focused therapies (with exposure and/or cognitive restructuring, such as prolonged exposure or cognitive processing therapy), stress inoculation training (anxiety management and stress reduction techniques), and eye movement desensitization and reprocessing, along with pharmacotherapy as necessary for management of depression or other symptoms for treatment of severe PTSD.

According to VA, following these guidelines is time and staff-intensive, but ultimately results in better outcomes for veterans. However, hiring mental health providers and ensuring that adequate numbers of staff are fully trained in using these techniques has been an ongoing challenge for VA. VA reports that it has trained 6,800 staff in its medical centers and in Vet Centers in using these guidelines but this specialized treatment and recommended adjunct care modalities of care such as psychosocial rehabilitation are not available at all VA facilities. The working group also opined about the lack of evidence-based practices for concurrent treatment of common comorbidities such as mild TBI, substance use disorders (SUD), depression and other mental health conditions. We share this concern and hope that VA researchers continue to identify approaches that will fill this knowledge gap. Unfortunately, some of these therapies are viewed by patients as too intense, leading many veterans to drop out. For these reasons, we concur that complementary and alternative therapies showing benefit must also be available to those who need help.

DAV supports the use of these clinical guidelines, and looks forward to reviewing the updated recommendations. Wide dissemination and training on these standards of care better ensures that veterans have the most effective care, but sufficient resources must follow to ensure adequate staffing levels so that veterans have timely access and availability to these specialized services.

Far from easing the access issue for veterans, contracting care to private-sector providers (through the current Choice program or existing contracts) without supplementing VA's budget may actually exacerbate the problem. Few providers in the private sector have the specialized training necessary to use the VA/DOD clinical practice guidelines with fidelity. In addition, directing resources away from VA has the potential to compromise VA's ability to provide high quality mental health care and the most appropriate care for veterans. DAV appreciates the need for access to community care and supports veterans' access to such care in certain circumstances, but we are also concerned about the risks to current programs if sufficient funding is not provided to ensure veterans who want to remain in VA care for its specialized mental health care services can do so.

We continue to hear from front line mental health providers that the outdated scheduling package and Choice rules often impede their ability to provide the most appropriate care for their veteran patients and urge veterans to accept care in the community if they must wait over 30 days to see a provider—even when they prefer to remain in VA so they can see their established provider. One clinician argued that in focusing so narrowly on addressing and avoiding future scheduling manipulation, VA has inadvertently created a more rigid system that disempowers and endangers the veterans that they were supposed to protect. For example, a woman veteran suffering from PTSD due to MST who is stable with her psychiatrist and now is pressured to “choice out.” The frustrated clinicians call it the “non-choice” program. One provider stated, “I don't know who makes up these scheduling rules but probably individuals who don't understand the meaning of the metrics produced and don't understand the impact where the rubber meets the road, in the personal lives of each veteran. As long as the veteran is not in crisis and acknowledges it his/her choice to delay a visit in order to stay with his/her psychiatrist, why would we not empower that veteran to make that choice?” As Congress and VA move forward with plans better integrate VA and community care options we urge VA to engage with front-line providers and veterans to determine a proper balance that allows clinicians and veterans to make appropriate health care decisions and choices based on their needs and desires.

Crisis Management and Suicide Prevention in the Veterans Health Administration (VHA)

Suicide among veterans is a complex problem that VA cannot solve alone. Over the last decade, the number of veterans seeking specialized mental health care from VA has almost doubled. In response to this rapid growth, VA has implemented new programs, enhanced existing ones, and hired more personnel; yet the number of veterans committing suicide remains too high to bear (about 7,300 per year). Despite these numbers, the fact that VA patients are less likely to commit suicide and, in fact, are more likely to live beyond the years of life expected for those diagnosed with serious chronic mental illness is a strong testament to the effectiveness of VA's mental health programs. Integrating mental health into primary care helps with early identification and treatment of those who regularly rely upon VA for care. Outside of VA, however, veterans lack access to the same specialized and comprehensive mental health care services and the cultural competency of VA providers. Additionally, medical records are not routinely shared and care is not coordinated. This results in care that is disparate, fragmented and may even work at cross purposes.

To do our part, during National PTSD Awareness Month, DAV distributed information to our National Service Officers and Transition Service Officers, who serve hundreds of veterans every day, on how to effectively handle calls from veterans in distress, and refer callers to the Veterans Crisis Line when appropriate. DAV will also continue to advocate for effective policy, and promote VA's awareness campaigns that assist veterans with post-deployment challenges, treatment for military sexual trauma and mental health issues. We look to Congress for continued oversight and introduction of legislation necessary to improve mental health services for our nation's veterans with a goal of putting an end to the national crisis of veterans' suicide.

We do however recognize our efforts must extend beyond Capitol Hill and beyond the outreach of traditional veterans service organizations to reach those veterans at greatest risk. We must all take time to learn the warning signs of distress, and know the proper actions to take

when we see them. We must all do our part to help to remove the stigma associated with seeking mental health counseling and treatment. We must communicate to veterans that it is okay, even brave and wise, to seek the care that they have earned through their service to this nation. DAV is a committed partner in this effort and we encourage everyone to do their part with a shared goal of ending veterans' suicide.

The high rate of veterans' suicide and the media attention to this issue has at times called into question VA's ability to effectively manage veterans in mental health crises. To understand how suicide prevention efforts can be improved in VA one must assess the whole spectrum of programs the Department has in place. There are opportunities to reduce stigma, improve outreach, screening, treatment and recovery potential. While VA has made tremendous strides in identifying veterans at risk of suicide and treating those within its care, the fact is many—about three quarters—of the veterans that commit suicide are not VA patients. Eligibility barriers, limited resources, hiring issues and challenges with community collaboration, including difficulties exchanging medical information with private sector providers, complicate VA's ability to reach these individuals.

Given these specific challenges, it is essential for VA to partner with nonprofit organizations such as the National Alliance on Mental Illness and the National Association for Mental Health, and with private sector providers (psychiatrists, psychologists, social workers, and community social workers) who want to help capture all veterans who need help. However, increased efforts to improve fundamental education about the needs of the veteran population for non-VA providers will be necessary so they can effectively treat veterans with service-related conditions such as PTSD, TBI or issues related to military sexual trauma.

One area VA can improve and better serve veterans is crisis management. Over the last two decades, VHA has had to adapt to fill the gaps in its benefits package for emergency medicine and urgent care at many locations. Immediacy is fundamental to effectively addressing the needs of individuals in crisis and/or with suicidal ideation. While VA has good policies and directives in place, unfortunately, most VA medical centers do not operate as round-the-clock providers. While hospitals are always open, admission criteria for mental health inpatient programs are stringent. Unless the veteran proclaims that he or she is a threat to himself/herself or others (in which case they are admitted) they are likely to be evaluated and given an appointment for a later time.

While VA has recently amended its emergency medicine directive (VHA Directive 1101.05) to standardize care provision and ensure that necessary staff, including mental health professionals, are available onsite and 24/7 by phone, there are still, at times in certain locations, problems in accessing mental health care.

Only VA's "level 1" facilities are likely to have emergency departments that are required to be staffed by a physician and nurse 24/7; the most medically advanced of these (level 1a) are required to have mental health available onsite from 7 a.m. to 11 p.m. and on-call other hours. These facilities are advised to have a psychiatric intervention rooms for patients who are seriously disturbed, agitated or intoxicated, but do not meet the "life or death" criteria for admission to an inpatient psychiatric bed. Other facilities may have "urgent care centers" that

only operate during normal business hours. In addition, certain enrolled veterans (those who have used VA care within the last two years and have no other health care coverage) are eligible for emergency care from community providers at VA's expense. However, this benefit has proven difficult to administer and difficult for veterans to understand, particularly when in a health crisis. We urge Congress to reduce the administrative burden for this benefit as it considers and redefines veterans' access to emergency care services in the community.

Because VA emergency care is not always accessible to veterans and in light of the continuing crisis of veterans suicides, in 2008, VA established a crisis line. The Veterans Crisis Line (VCL) has become a critical part of VA's care management plan for extremely vulnerable veterans—those in distress, crisis or with suicidal ideation. Based on the number of calls, it is clear the VCL tapped into a tremendous unmet need. Since first activated, call volume has grown by 700 percent and such rapid growth resulted in a number of issues related to this life-saving service.

Congress has justly criticized VA for VCL's problems with timeliness and availability in responding to veterans' calls or text messages. As recently as this April, the Government Accountability Office (GAO) testified that VA did not meet its call response time goals for more than a quarter of its calls (GAO 17-545T). It also found that a significant portion (29 percent) of "test" texts went unanswered. Veterans have also mistakenly reached "Lifeline"—a shared public-private crisis intervention line rather than the VCL on some occasions, but VA has not looked into the extent of the problem nor why this has occurred. Finally, GAO found that VA lacked measurable goals and timelines to address identified issues and implement suggested improvements.

The VCL provides more than just a sympathetic ear—it's a critical part of the mental health safety net for our veterans. Its specially trained responders send ambulances and make referrals to local VA facilities' suicide prevention teams or coordinators to ensure they follow-up with the veterans who use its services. In light of the essential service it performs, DAV believes ensuring that VA fixes the problems identified by GAO should be among the Committee's oversight priorities. Congress needs to maintain oversight of this program and ensure VA is given the necessary resources to provide these essential services to veterans in crisis.

There are two initiatives underway to improve care for veterans using VA mental health care services that are worth noting. The VA's Recovery Engagement and Coordination for Health (REACH) VET initiative uses a predictive model to systematically flag charts of veterans who may be at risk of suicide. This allows VA to identify and treat high risk veterans *before* a crisis occurs. VA is also proposing a Measurement Based Care initiative that will allow veterans using mental health services to identify changes in symptoms and how they are able to manage their daily life activities. Under this initiative, reviewing treatment progress and goal-setting with veterans become central to mental health encounters. We believe this initiative is more veteran-centered and has a great deal of potential in identifying the most important and effective treatment for an individual veteran. Analysis of VA's current mental health services required under the Clay Hunt SAV Act (Public Law 114-2) should also help VA understand how these initiatives affect patient outcomes and the effectiveness of its suicide prevention efforts.

Readjustment Counseling Service—VA Vet Centers

One VA's most popular programs is provided through its Readjustment Counseling Service (RCS). Through community Vet Centers, Mobile Vet Centers, and the Vet Center Call Center, VA is able to provide non-traditional readjustment services that are driven directly by the needs of war veterans, active duty service members, and their families. Vet Center staff, many of whom are veterans themselves, conduct important outreach to fellow veterans and focus on the therapeutic relationship, individual treatment plans, and providing a non-medical model of readjustment counseling that encompasses services for a spectrum of clinical and socio-economic issues. According to RCS, in fiscal year (FY) 2016, Vet Center staff participated in over 40,000 outreach events and increased access at Vet Centers to veterans by 18 percent over the previous fiscal year.

Vet Center staff also focus on decreasing known barriers associated with receiving readjustment counseling and are purposely positioned in the community to create easy access points for the veterans they serve. We are pleased to see RCS is increasing its flexibility and expanding its services beyond traditional brick-and-mortar Vet Centers through the use of Vet Center Community Access Points (CAPs). Through CAPs, VA clinicians are able to provide readjustment counseling from these locations that is more in line with the needs of the community and can range from once a month to several times a week. This approach allows Vet Center staff to move with veterans and service member population as demand changes.

Vet Center staff also respond to major emergency events and frequently partner with the Red Cross providing clinical support in local communities in the aftermath of shootings, floods and other disasters. As a testament to their effectiveness and popularity Vet Center services appear to be steadily increasing. In FY 2016, RCS provided over 1.7 million readjustment counseling visits and outreach contacts (8.2% increase over FY 2015) for 258,396 veterans, service members, and families (17.7% increase over FY 2015). The Vet Center Call Center handled 116,596 live telephone calls from veterans, service members, families, and community stakeholders (3% increase over FY 2015).

Expanding Access to Veterans with Discharges Characterized as Other Than Honorable

One group that has traditionally lacked access to VA care are those with military service discharges characterized as other than honorable. Ironically, among veterans with these discharges many may have undiagnosed or untreated mental health conditions or mild traumatic brain injuries (TBI) that may have contributed to their misconduct during service. A recent GAO report (GAO-17-260), indicated that 62 percent of service members separated from service because of misconduct had been diagnosed with TBI, PTSD or other mental health conditions in the preceding two years. DOD policy requires that TBI and PTSD be considered in determining the characterization of discharge, yet 23 percent of these individuals received "other than honorable" discharges. Likewise, longstanding VA policy created eligibility barriers for VA health care services for many of these veterans. We commend Secretary Shulkin for revisiting this policy to allow an estimated 500,000 veterans with other than honorable discharges to seek urgent mental health care and potentially prevent these veterans from injuring themselves or others due to untreated mental health conditions. The Vet Center program will likely be primary

providers of this service. As such, additional funds should be provided to meet expected increased demand.

Use of Peer Specialists

DAV fully supports VA's Peer Specialist Program and we believe there are more opportunities to integrate peers in VA's mental health programs and related services. VA has hired 1,100 peer specialists to assist their peers by providing patient education, coordinating appropriate care, and assisting veterans with maintenance of clinicians' orders for managing mental health conditions. As VA began to hire peers, some clinicians expressed concerns about vague duties and oversight but these concerns seem to have been addressed by developing specific job descriptions, requiring certification and creating job-specific core competencies to ensure incumbents have the requisite skills. We understand that VA plans to expand its use of peer specialists into primary care settings as part of the integration of mental health into primary care.

DAV supports using peer specialists as a means of expanding VA's workforce and providing additional support to veterans with complex and comorbid conditions such as PTSD, SUD and TBI. Use of peers has been shown to enhance patient engagement, increase their self-advocacy skills, ensure more appropriate use of services, and increase patient satisfaction and quality of life. Such time-honored programs as Alcoholics Anonymous and other addiction recovery programs operate solely as peer-sponsored support programs. The National Alliance for Mental Illness also advocates and exploits these models to help those with mental illness progress toward recovery.

Early on, VA saw the benefits of peer interaction with veterans with serious mental illness and has promoted this model of peer-support. VA's Vet Center program has always embraced this model and was specifically developed to reflect the communities they serve. These individuals are able to effectively connect with a veteran because of their shared experience of military service. Overall, peer specialists play an important role and can improve veterans' care outcomes and assist VA with cost containment by helping some of the system's most fragile and complex care patients better manage their own care.

We continue to hear VA clinicians perceive peer specialists as valuable members of their clinical care teams. The Clay Hunt SAV Act sought to take on a broad community-based approach by establishing a pilot program to develop peer networks with community outreach teams to better collaborate with local mental health organizations. Unfortunately, in identifying implementation barriers for Clay Hunt provisions, VA reports they do not have funds available for hiring or training additional peer specialists. We urge the Committee to consider this information as they work through the budget process and make recommendations.

As noted, we see additional roles for peer specialists including assisting with deescalating veterans in crisis, following up with intensive care users to ensure they are following their care regimens, serving as points of contact or mentors for the veteran as they establish trusting relationships with mental health providers or are waiting for services. They can also assist veterans with navigating the VA system and highlight various services and treatment options.

Outreach

We applaud VA for development of its excellent outreach campaigns. VA credits its “Make the Connection” campaign with successfully linking many veterans and family members to needed health care resources. Public awareness campaigns are essential in addressing the stigma many veterans still confront in seeking mental health care by alerting veterans, family members, and members of the community to the high rates of suicide in the veteran population and educating the broader community about the signs and symptoms of mental illness.

VA’s Coaching into Care initiative has been a successful telephone program that employs VA mental health professionals to assist family members and friends with identifying ways to motivate veterans to seek mental health care treatment and locating local resources. DAV supports this innovative program as a way of offering help to families in crisis that may pre-empt veterans from harming themselves, their loved ones, or others.

DAV supported the Clay Hunt SAV Act addressing veteran suicide through a multi-faceted approach including public awareness, assisting veterans and family members with obtaining care and building coalitions between national nonprofits and local providers who want to treat veterans who are not willing or able to use VA health care. We agree that meeting the individual needs of all veterans with post-deployment readjustment and/or mental health issues will require collaboration and education of private sector primary care providers, mental health providers and clinicians providing SUD treatment. The Clay Hunt SAV Act requires joint collaboration and information sharing with non-governmental mental health providers to reach veterans who are unaware, unwilling or unable to access VA services. Collaborations with VA providers and nonprofits at the local and community level could help identify veterans at high risk of suicide who are not using VA for health care. Full implementation of this law would also assist veterans in identifying all available mental health resources in their community by creating web-based repositories for each Veterans Integrated Service Network.

In closing, we appreciate the opportunity to provide testimony for the record. We ask the Committee to consider our views as it deals with its legislative plans for this year. I will be happy to address any questions from the Chairman or other Members of the Committee.